Lesson Objectives

Other Activities

After this lesson, you should be able to:

- Identify special programs
- Locate contact information for special programs
- Identify who is affected by the Health Insurance Portability and Accountability Act (HIPAA)

TRICARE's Other Activities

- US Family Health Plan (USFHP)
- Extended Care Health Option (ECHO)
- Computer/Electronic Accommodations Program (CAP)
- TRICARE Plus
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Uniformed Services Family Health Plan

(USFHP)

Background:

- The USFHP started serving military beneficiaries in 1993 under a contract with the Department of Defense (DoD).
- In 1998, the DoD contracted with six former U.S. Public Health Service hospitals to become TRICARE Prime-designated providers through the administration of USFHP programs.

USFHP offers:

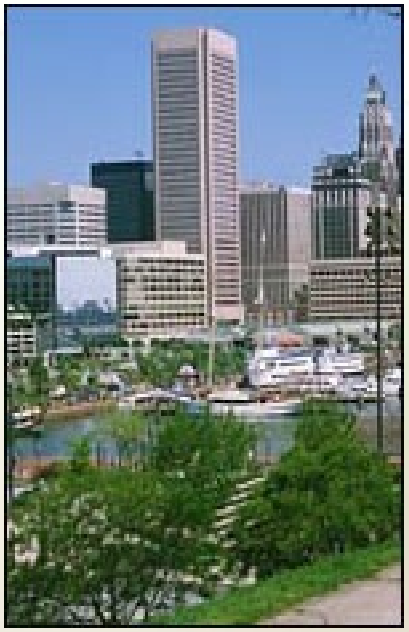
- The same health care benefits as TRICARE Prime
- Program-specific enhancements, to include self-referring, well-woman exams, dental, eye care, and hearing aid options and discounts.

The USFHP uses the same cost shares as Prime for enrolled eligible persons as long as USFHP enrollees use the not-for-profit hospitals and healthcare systems named as designated providers as their only care providers.

Eligibility for USFHP Coverage

To be eligible for the US Family Health Plan (USFHP), beneficiaries must:

- Live in a specific ZIP code-based prime service area around one of the designated hospitals or clinics; each USFHP service areas includes a network of providers
- Have no other comprehensive health insurance (besides Medicare)
- Fall into one of five categories (detailed on the following slide)



Eligibility is determined through the Defense Enrollment Eligibility Reporting System (DEERS), so it is important that beneficiaries update their records and keep them current.

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Eligibility Categories

To be US Family Health Plan (USFHP) eligible, one must be:

- An eligible Active Duty Family Member (ADFM)
- A Uniformed Services retiree - including those age 65 and over
- An eligible family member of Uniformed Services retirees - including those age 65 and over
- An eligible family member of deceased Active Duty or retired Uniformed Services members - including those age 65 and over
- A Qualifying re-activated Reserve Component family member

Active Duty members are not eligible for USFHP.

Enrollment in USFHP

- To enroll in the US Family Health Plan (USFHP), eligible beneficiaries have to complete and submit an application to the USFHP program of their choice.

- This can be completed anytime throughout the year.

- Beneficiaries can learn more about each of the designated providers, the services that are covered by the USFHP when provided or authorized by a USFHP primary care provider by visiting: **http://www.usfamilyhealthplan.org/newsite/portal/default.asp**

Enrollment in USFHP

Enrollment in the US Family Health Plan is contingent on space availability and requires a one-year commitment to receive care from USFHP/Designated Providers.

- The exception to this rule is if a beneficiary moves out of the area or his/her eligibility status changes.

Like TRICARE Prime, USFHP enrollees must pay an annual enrollment fee:

- $230 for one person
- $460 for a family.

The enrollment fee is waived for:

- Active Duty Family Members, and
- Persons who are Medicare eligible and enrolled in Medicare Part B.

USFHP/Designated Provider Hospitals and Clinics

- **Saint Vincent Catholic Medical Centers of New York**
  450 West 33rd Street, New York, NY 10001.
  Telephone: 1-800-241-4848
  www.usfamilyhealthplan.org
  Serving New York, all of New Jersey, eastern Pennsylvania, and southern Connecticut.

- **Johns Hopkins Medical Services Corporation**
  6704 Curtis Court, Glen Burnie, MD 21060
  Telephone: 1-800-808-7347
  www.hopkinsmedicine.org/usfhp
  Serving Maryland, Washington, DC, Pennsylvania, Virginia, and West Virginia.

- **Brighton Marine Health Center (in conjunction with St. Elizabeth's Medical Center)**
  P.O. Box 9195, Watertown, MA 02471
  Telephone: 1-800-818-8589
  Serving Massachusetts and Rhode Island.

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USFHP/Designated Provider Hospitals and Clinics, continued

- **Martin's Point Health Care Center**
  P.O. Box 9746, Portland, ME 04104-5040.
  Telephone: 1-888-241-5040
  www.usfamilyhealthplan.org
  Serving Maine and southern New Hampshire.

- **Pacific Medical Clinics (PacMed Clinics)**
  1200 12th Avenue South, Seattle, WA 98144.
  Telephone: 1-888-958-7347
  www.pacmed.org
  Serving the Puget Sound area of Washington State.

- **Christus Health (covering Southeast Texas and Southwest Louisiana)**
  P.O. Box 924708, Houston, TX 77292-4708
  Telephone: 1-800-678-7347
  www.usfamilyhealthplan.org

USFHP: Provider Conditions

Once enrolled in the US Family Health Plan (USFHP), all care that is cost shared by the government must be provided by the USFHP/Designated Provider or the approved network of providers.

Since the USFHP offers comprehensive health coverage and pharmacy benefits, USFHP enrollees cannot use services within the Military Health System (MHS). This includes:

- The MTF pharmacy,
- TRICARE retail pharmacies and
- TRICARE Mail Order Pharmacy.

USFHP: Provider Conditions - *Exceptions*

The exceptions to limiting care to US Family Health Plan (USFHP)/Designated Providers (DP) are:

- Beneficiaries who are traveling (see "Portability," to follow);
- Beneficiaries referred to a military treatment facility by a USFHP/DP provider;
- Beneficiaries with an acute medical emergency while located closer to a military treatment facility than the USFHP/DP; or
- New enrollees who are pregnant and wish to complete their prenatal care at their previous military treatment facility (dependent on the MTF)

Beneficiaries included in any of these categories may receive care from a provider other than the USFHP/DP.

USFHP: No Point of Service

The US Family Health Plan's (USFHP) Prime-like benefit does not include the Point of Service (POS) option.

The POS option was designed to allow TRICARE Prime enrollees get care from a provider of their choice without referral or authorization. You will pay 50% of the TRICARE allowable charge after the annual deductible is met:

USFHP members must pay the full amount for the care they receive if they seek care outside the USFHP network.

USFHP and Medicare

- A beneficiary who is age 65 or over and is eligible for Medicare Part A does not have to enroll in Medicare Part B to qualify for US Family Health Plan (USFHP) enrollment.

- The Department of Defense encourages Medicare eligible beneficiaries to enroll in Part B when they first become Part B eligible (if other than an active duty/active duty family member)

- Failure to enroll, or remain enrolled, in Medicare Part B when first eligible will result in a beneficiary paying an annual Medicare penalty surcharge (for life) if they disenroll from the USFHP at some point and participate in TRICARE For Life instead.

- If a Medicare-eligible beneficiary has never enrolled in Medicare Part B and wants to have health care coverage without paying the surcharge and the beneficiary lives within the specific ZIP code catchment area of one of the designated hospitals, USFHP may be an option for the individual.

USFHP and Medicare

A beneficiary who is **under the age of 65 and is Medicare-eligible due to a disability, or end stage renal disease** must be enrolled in Medicare Part B to be eligible for TRICARE benefits including enrollment in the US Family Health Plan (USFHP). (This does not apply to Active Duty Family Members).

- These beneficiaries do not have to pay the TRICARE Prime or the USFHP enrollment fee.

A beneficiary enrolled in Medicare Part B must not use his Medicare benefits for services covered under the USFHP.

- Beneficiaries enrolled in Medicare Part B do not have co-payments for services that would otherwise be covered by Medicare.

USFHP and Portability

- If an enrollee is **traveling**, he/she needs to transfer his/her enrollment to a second US Family Health Plan (USFHP) Designated Provider (DP) or to an area where TRICARE Prime is offered.
  - A beneficiary can make such a transfer twice during the enrollment year -- as long as the second transfer is back to the original USFHP/DP site of enrollment.

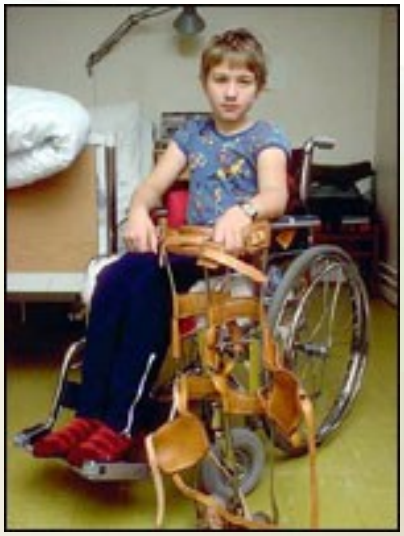
- **If moving**, non-Medicare USFHP enrollees may transfer from their home USFHP/Designated Provider (DP) to another USFHP/DP or to TRICARE Prime if offered in their new location.

- TRICARE For Life beneficiaries can switch enrollment from TRICARE For Life to USFHP/DP where available.
  - As long as Medicare Part B enrollment remains current, these beneficiaries still have TRICARE For Life coverage.

- USFHP beneficiaries must disenroll from USFHP if they move to an area where USFHP is not available.

Extended Care Health Option Program (ECHO)

The Extended Care Health Option (ECHO) is a non-enrollment benefit program that is used concurrently with other TRICARE medical programs to provide financial assistance to certain individuals with physical and mental disabilities.



To be eligible for the ECHO benefit, an individual:

- Must be an eligible active duty family member
- The disability in question must substantially limit major life activities, such as eating, communicating, and mobility.

If the qualifying condition existed before reaching age 21, the beneficiary retains eligibility as long as the sponsor remains on Active Duty.

ECHO… continued

Active duty family members, or persons acting on their behalf, who apply for Extended Care Health Option (ECHO) benefits must show that the medical condition qualifies the family member for the program and that the requested benefits are necessary.

Though the ECHO benefit does not require enrollment, beneficiaries must apply for and obtain approval before receiving services if they plan on cost sharing with TRICARE.

TRICARE Prime enrolled beneficiaries who are enrolled in ECHO must meet TRICARE Prime requirements even when they receive services through ECHO (i.e.: using his PCM for specialty care referral).

ECHO: Cost Shares

Under the Extended Care Heath Option, the sponsor is required to pay part of the monthly cost share for his or her family member's care.

This cost share depends on the sponsor's pay grade.

Sponsor Pay Grade	Sponsor Cost Share Amount
E-1 to E-5	$25
E-6	$30
E-7, O-1	$35
E-8, O-2	$40
E-9, W-1, W-2, O-3	$45
W-3, W-4, O-4	$50
W-5, O-5	$65
O-6	$75
O-7	$100
O-8	$150
O-9	$200
O-10	$250

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ECHO: Costs

For one eligible person with a qualifying disability, TRICARE pays as much as $2,500 per month for Extended Care Health Option (ECHO) benefits.

- The beneficiary is responsible for the monthly cost share amount as well as any costs over $2,500.

If two or more persons with the same sponsor receive services under ECHO, TRICARE will require payment of one monthly cost share by the sponsor and TRICARE will pay $2,500 for each ECHO eligible beneficiary.

- The sponsor's monthly cost share remains the same.

ECHO:
Using Basic TRICARE Programs Benefits

Sometimes, **not** using the Extended Care Health Option (ECHO) benefits for diagnostic and treatment services can save beneficiaries money.

- Families may choose to get some services under the basic TRICARE programs (Prime, Extra, or Standard).
- This could possibly allow the sponsor to only pay a maximum of $1,000 in a fiscal year for TRICARE-covered services (this is called the "catastrophic cap" on expenses for ADFMs).

It is very important that the beneficiaries work closely with their ECHO Case Manager when using their ECHO and basic TRICARE benefits.

ECHO: Using Public Funds

Many states offer financial assistance to people with disabilities. TRICARE recommends beneficiaries get familiar with local and national community resources so they can get answers to questions and assistance in addressing their healthcare concerns.

- Families should take advantage of these community resources should while seeking aid from TRICARE.
- If local resources are not available, TRICARE will cost share payment for covered services.

When requesting Extended Care Health Option (ECHO) benefits, the family must include a letter from the proper public official detailing the lack of public help.

As with other TRICARE program benefits, all providers of ECHO services, supplies, and equipment must be TRICARE authorized providers.

ECHO: USFHP

- Under US Family Health Plan, the Specialty Care Case Manager will determine eligibility for the Extended Care Health Option (ECHO) for a family member, enrolled in Exceptional Family Member Program (EFMP), diagnosed with medical condition requiring care.

- The Specialty Care Case Manager has guidelines which outline what information is required to establish the existence of a qualifying medical condition. Likewise, the Specialty Care Case Manager's has information that outlines how a beneficiary can establish the medical need for certain benefits and services.

ECHO: Pre-Authorized Benefits

- Any claim submitted for Extended Care Health Option (ECHO) benefits should include a copy of the written pre-authorization form.
- To receive payment for any services or supplies under the ECHO program:
  - Individual TRICARE authorized providers submit the HCFA 1500 claim form.
  - Institutional providers submit the UB-04 form.
  - Beneficiaries submit a DD Form 2642 ("Patient's Request for Medical Payment").
- Anyone under the ECHO, regardless of age, is covered for general medical care.
- Claims are sent to the TRICARE claims processor associated with the region where the patient resides.
- If the Active Duty member is transferred, the family must get new benefit authorizations in their new region. They can contact the new region's managed care support contractor's ECHO case manager.

Computer/Electronic Accommodations Program (CAP)

- **The Computer/Electronic Accommodations Program (CAP) is a centrally funded reasonable accommodations program for employees with disabilities in the Department of Defense (DoD).**
- The CAP mission is to:
  - “Provide real solutions for real needs to ensure people with disabilities have equal access to the information environment and opportunities in the Department of Defense and throughout the Federal Government."
- The DoD established the CAP to provide people with disabilities equal access to technology and informational systems.
  - The Program assists military treatment facilities in meeting communication accessibility requirements by satisfying the needs of employees with disabilities and facilitating communication between patients and government officials.
- CAP is available to all disabled DoD employees as well as to DoD staff members who need to provide information and services to beneficiaries with disabilities using the MHS, MTF, or Exceptional Family Member Program.
- For more information on the CAP, go to **htttp://www.tricare.mil/cap/**

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How CAP Works

- Computer/Electronic Accommodations Program (CAP) staff can help beneficiaries identify and purchase appropriate assistive technologies that will provide optimal assistance for disabled beneficiaries.

- CAP also trains end-users on how to use assistive technologies.

- And lastly, CAP coordinates closed captioning for government-produced videos.

- If someone in a military treatment facility needs to communicate with a beneficiary who requires assistive technology for communication, the military treatment facility staff and contact the CAP staff for assistance.

CAP-Examples of Assistive Technology

Blind or low vision

The following assistive technology (AT) might be used by a military treatment facility employee perform daily job-related responsibilities, or it may be used by patients to accomplish tasks like completing forms:

- Closed Circuit Televisions (CCTV)
- Screen magnification software
- Screen reading software (text-to-speech synthesizer)
- Large print formatted materials
- Braille reader or printer

CAP-Examples of Assistive Technology

Deaf or hard of hearing

The following assistive technology (AT) might be used by a military treatment facility employee to perform daily job-related responsibilities, or it may be used by patients at appointment desks, waiting rooms, or pharmacies:

- Teletypewriters (TTY) – Send and receive messages via a phone using a typewriter and visual display
- Amplified telephones
- Assistive listening devices – Personal amplification systems

CAP-Examples of Assistive Technology

Dexterity disabilities

The following assistive technology (AT) might be used by a military treatment facility employee to perform daily job-related responsibilities, or it may be used by patients to communicate with medical staff or to fill out a form:

- Alternative keyboards and pointing devices – Operated with the foot, head, or retina
- Voice recognition software – Allows a user to input data and navigate a computer using only his voice

CAP-Cognitive and communication disabilities

Cognitive disabilities are diverse and often cannot be accommodated with a generic type of assistive technology (AT).

Instead, a combination of AT might be used.

- For instance, someone with dyslexia may use voice recognition software to dictate a document and a screen reading software to read a document.
- This technique could also be used by someone with a learning or attention disability who has difficulty typing or reading.

TRICARE Plus

- TRICARE Plus was implemented to provide beneficiaries primary care access at a military treatment facility (MTF) without requiring them to enroll in TRICARE Prime.
- This is an MTF program, the parent Service retains oversight and therefore this option is not available at all MTFs.
- The local MTF will review beneficiaries' enrollment in TRICARE Plus annually and may find the need to disenroll them if capacity is no longer available.

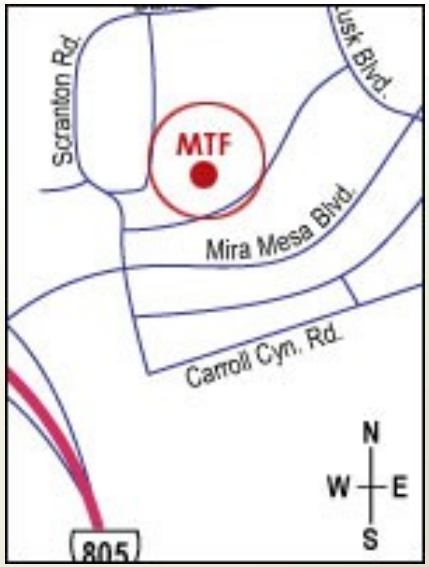
TRICARE Plus

- TRICARE Prime and TRICARE Plus are managed care programs. These programs are mutually exclusive- a beneficiary may participate in one or the other, but not both. Additionally, beneficiaries may not be enrolled in a civilian HMO or Medicare HMO while covered under TRICARE because they have established a primary care relationship with another provider.

- Note: TRICARE Plus is not a comprehensive health plan and it is not portable to other MTFs.

TRICARE PLUS: Enrollment

- Enrollment in TRICARE Plus is free and its availability is based on each military treatment facility's (MTF) capacity to take on additional enrollees.
- Availability is determined locally by the facility's commander.
- Only beneficiaries who live within the Prime service are of a participating MTF will be eligible for enrollment in TRICARE Plus.
- One exception to this rule is if the MTF commander waives this requirement for a particular beneficiary due to an outstanding circumstance.
- Once enrolled, a beneficiary's enrollment is documented in DEERS.



Using TRICARE Plus

TRICARE Plus enrollees receive primary care within the TRICARE Prime access standards.

- Plus enrollees use their designated primary care manager (PCM) at the military treatment facility (MTF) as their principal source of health care.
- The PCM then refers the beneficiary to an MTF specialist when space and capability are available.

TRICARE Plus enrollees are strongly discouraged from obtaining non-emergency primary care from sources outside the MTF where they are enrolled.

- If the PCM refers the beneficiary to a civilian provider for medically necessary specialty care because such care is not available in the MTF, TRICARE Standard or TRICARE Extra rules will apply.

The Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was passed to:

- Improve the portability of health insurance coverage
- Combat waste, fraud, and abuse, and
- Simplify health care administration.

HIPAA is comprised of three basic rules:

- Rule 1: **Transactions and Code Sets**
- Rule 2: **Security**
  - (Technical, and will be transparent to the beneficiary)
- Rule 3: **Privacy**, has the most impact on the beneficiary and workforce

The HIPAA Privacy Rule

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule establishes standards outlining how Protected Health Information (PHI) can be used and disclosed.

PHI is "individually identifiable health information including demographics that is in paper, electronic, or verbal medium."

Compliance with the HIPAA Privacy Rule was established on April 14, 2003 and nearly every party involved in the health care process was, and still is, affected by this policy change.

The HIPAA Privacy Rule

Who is Affected by Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule?

- Health plans (TRICARE)
- Providers
- MTFs
- Dental Clinics
- Pharmacies
- Managed care support contractors (MCSCs) and other business associates
- Health care clearinghouses (e.g., MCSC subcontractors)

The HIPAA Privacy Rule requires TRICARE provide beneficiaries with a Notice of Privacy Practices.

The Notice describes how the Military Health System may use or disclose protected health information and key patient rights.

Key Patient Rights Under HIPAA Privacy Rule

Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, **patients have the right to:**

- Request and receive documentation explaining Military Health System privacy practices regarding their health information
- Request access to, or obtain a copy of, their protected health information (PHI) on file at a military treatment facility (MTF)
- Request an amendment to their PHI
- Request an accounting of disclosures of their PHI (PHI can be disclosed for research purposes)
- Request a restriction of uses and disclosures of their PHI
- File a complaint regarding health information privacy infractions

Closed Medical Records System

- TRICARE's Closed Records System is mandated by the Assistant Secretary of Defense for Health Affairs.
  - The system enables military treatment facilities (MTFs) to maintain custody of their beneficiaries' medical records at all times.
  - This means the records never leave the MTF while a beneficiary is enrolled there.
  - This eliminates the possibility of losing medical records and ensures record availability at all times.

- This policy ensures that current information such as lab reports, radiology results, medications, and treatment plans are filed in a patient’s medical records.

- This system simplifies the process for beneficiaries, who do not need to pick up and return their medical records after every appointment within the MTF.

- If beneficiaries are referred for care outside the MTF and need their medical records, they are to contact the local patient administration division, MTF privacy officer, or outpatient medical records office at the MTF for guidance.

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Summary

Congratulations, you've finished Other Activities!

You should now be able to:

- Identify special programs
- Locate contact information for special programs
- Identify who is affected by the Health Insurance Portability and Accountability Act (HIPAA)